Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DEC OF TEXAS, INC.
601 TEXAN TRAIL SUITE 201
CORPUS CHRISTI, TEXAS 78411

Respondent Name

FEDERAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 17

MFDR Tracking Number

M4-12-1351-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: From the Table of Disputed Services: "CLMT SCHEDULED FOR DDE TO ADDRESS MMI & IR. AUDITING CO. DENYING PAYMENT STATING "CLAIM LACKS INFORMATION NEEDED FOR ADJUDICATION." I DID RECONSIDERATION AND RECEIVED SAME DENIAL. REQUESTING YOUR ASSISTANCE IN GETTING REMAINING BALANCE PAID." And from a letter dated February 17, 2012: "After further review I have enclosed a corrected HCFA 1500 illustrating 99456-W5-WP. The RE has been taken off."

Amount in Dispute: $375.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor saw the Claimant for an examination to determine maximum medical improvement (MMI) and impairment rating (IR). However, when they billed for this examination, they used the coding 99456-W5-RE. DWC Rule 134.204 (n)(7) states that the modifier "RE" shall be added to CPT code 99456 when a return to work or evaluation of medical care examination is performed. Requestor did not perform either of those examinations. Therefore, their bill could not be properly paid as they did not properly bill."

Response Submitted by: Downs Stanford, P.C., 2001 Bryan Street, Suite 4000, Dallas, Texas 75201

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 24, 2011	99456-W5-RE	$375.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   Explanation of benefits dated November 17, 2011
   - 16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.

   Explanation of benefits dated December 20, 2011
   - No reason codes listed or incomplete EOB presented.

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor billed the amount of $500.00 for CPT code 99456 with modifiers –W5 and –RE for Division ordered DD examination for Maximum Medical Improvement/Impairment Rating (MMI/IR). The Table of Disputed Services lists 99456 with modifiers –WP and –RE. It is noted that –RE is not an appropriate modifier for use with this billing and that a key modifier is missing on the bill submitted with the original DWC-60 packet on January 03, 2012. The explanations of benefits and MFDR respondent's DWC-60 response raise objections to improper modifier usage. The requestor submitted a corrected DWC-60 with a correction using modifiers –W5 and –WP which was submitted to MFDR on February 22, 2012 as a response to the letter from the carrier representative, Downs Stanford, P.C. However, the documentation presented does not support that a corrected billing with appropriate modifiers was submitted to requestor prior to MFDR. Therefore, no additional amount is recommended.
2. Respondent has already paid $125.00 on the billed CPT code 99456-W5-RE and no additional amount recommended by MFDR.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 09, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.